(ii) Initiate recovery of amounts previously paid, or reduce interim payments, or both.

(c) *Final determination and adjustment.* (1) After receipt of acceptable reports as specified in paragraph (b) of this section, CMS determines the total payment due the HMO or CMP for furnishing covered services to its Medicare enrollees (which is subject to the audit provisions of this subpart) and makes a retroactive adjustment to bring interim payments into agreement with the payable amount due the HMO or CMP.

(2) A final settlement may be made with the HMO or CMP even though a provider that is not owned or operated by the HMO or CMP or related to the HMO or CMP by common ownership or control and that provides services to the HMO's or CMP's Medicare enrollees has not had a final settlement with CMS under parts 412 and 413 of this chapter for services furnished by the provider to Medicare beneficiaries who are not enrolled in the HMO or CMP. In this situation—

(i) CMS must be satisfied that the costs of covered services furnished to the HMO's or CMP's Medicare enrollees, as shown in the reports specified in paragraph (b) of this section, are reasonable and that the interest of the Medicare program would best be served by not delaying final settlement with the HMO or CMP until there is a final settlement with the provider for services furnished to Medicare beneficiaries not enrolled in the HMO or CMP; and

(ii) Prompt settlement with the HMO or CMP would be in the best interest of the Medicare program if, for instance, the provider's costs represent an insignificant portion of total payment due to the HMO or CMP; or if CMS is satisfied that the provider's costs, as shown in the reports specified in paragraph (b) of this section, will not be modified, to any significant extent, by the final settlement with the provider under parts 412 and 413 of this chapter.

(d) *Notice of amount of payment.* The notice of amount of Medicare payment—

(1) Explains CMS's determination regarding total Medicare payment due the HMO or CMP for the contract period covered by the financial information specified in paragraph (b) of this section;

(2) Relates this determination to the HMO's or CMP's claimed total payable cost for that period;

(3) Explains the amounts and reasons, by appropriate reference to law, regulations, and Medicare program policy and procedures, if the determined amounts differ from the HMO's or CMP's claim; and

(4) Informs the HMO or CMP of its right to a hearing in accordance with the requirements specified in §405.1801(b)(2) of this chapter

(e) *Basis for retroactive adjustment.* (1) CMS's determination (as contained in the notice of amount of Medicare payment) constitutes the basis for making retroactive adjustments to any Medicare payment made to the HMO or CMP during the period to which the determination applies.

(2) Further payments to the HMO or CMP may be withheld or offset in order to recover, or to aid in the recovery of, any overpayment identified in the determination as having been made to the HMO or CMP, even if the HMO or CMP requests a hearing in accordance with the requirements specified in §405.1801(b)(2) of this chapter.

(3) Any withholding continues until the earliest of the following occurs:

(i) The overpayment is liquidated.

(ii) The HMO or CMP enters into an agreement with CMS to refund the overpaid amount.

(iii) CMS, on the basis of subsequently acquired information, determines that there was no overpayment.

(iv) The decision of a hearing specified in paragraph (d)(4) of this section is that there was no overpayment.

[50 FR 1346, Jan. 10, 1985, as amended at 51 FR 34833, Sept. 30, 1986; 58 FR 38082, July 15, 1993; 60 FR 34888, July 5, 1995; 60 FR 46231, Sept. 6, 1995; 73 FR 30267, May 23, 2008]

Subpart P—Medicare Payment: Risk Basis

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

§417.580 Basis and scope.

(a) *Basis.* This subpart implements those portions of section 1876 (a), (e), and (g) of the Act that pertain to the

amount CMS pays an organization for its Medicare enrollees who are enrolled on a risk basis.

(b) *Scope.* This subpart sets forth—

(1) Method of payment;

(2) Procedures for determining the HMO's or CMP's payment rate; and

(3) Procedures for determining the additional benefits (and their value) the HMO or CMP must provide to its Medicare enrollees.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46231, Sept. 6, 1995]

§ 417.582 Definitions.

As used in this subpart—

AAPCC stands for adjusted average per capita cost.

ACR stands for adjusted community rate.

Actuarial factors means factors such as the age, sex, and disability level distribution of the population and any other relevant factors that CMS determines have a significant effect on the level of utilization and cost of health services.

APCRP stands for average of per capita rates of payment.

Class of Medicare enrollees means a group of Medicare enrollees of an HMO or CMP that CMS constructs on the basis of actuarial factors.

Similar area means an area similar to the HMO's or CMP's geographic area but free from special characteristics that would distort the determination of the AAPCC.

U.S. per capita incurred cost means the average per capita cost, including intermediary or carrier administrative costs, incurred by Medicare, as determined on an accrual basis, for covered services furnished to Medicare beneficiaries nationwide during the most recent period for which CMS has complete data.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46232, Sept. 6, 1995]

§ 417.584 Payment to HMOs or CMPs with risk contracts.

Except in the circumstances specified in § 417.440(d) for inpatient hospital care, and as provided in § 417.585 for hospice care, CMS makes payment for covered services only to the HMO or CMP.

(a) *Principle of payment.* CMS makes monthly advance payments equivalent to the HMO's or CMP's per capita rate of payment for each beneficiary who is registered in CMS records as a Medicare enrollee of the HMO or CMP.

(b) *Determination of rate.* (1) The annual per capita rate of payment for each class of Medicare enrollees is equal to 95 percent of the AAPCC (as determined under the provisions of § 417.588) for that class of Medicare enrollees.

(2) CMS furnishes each HMO or CMP with its per capita rate of payment for each class of Medicare enrollees not later than 90 days before the beginning of the HMO's or CMP's contract period.

(c) *Adjustments to payments.* If the actual number of Medicare enrollees differs from the estimated number on which the amount of advance monthly payment was based, CMS adjusts subsequent monthly payments to take account of the difference.

(d) *Reduction of payments.* If an HMO or CMP requests a reduction in its monthly payment in accordance with § 417.592(b)(2), CMS reduces the amount of payment by the appropriate amount.

(e) *Determination of rate for calendar year 1998.* For calendar year 1998, HMOs or CMPs with risk contracts will be paid in accordance with principles contained in subpart F of part 422 of this chapter.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 52 FR 8901, Mar. 20, 1987; 58 FR 38082, July 15, 1993; 60 FR 46232, Sept. 6, 1995; 63 FR 35067, June 26, 1998]

§ 417.585 Special rules: Hospice care.

(a) No payment is made to an HMO or CMP on behalf of a Medicare enrollee who has elected hospice care under § 418.24 of this chapter except for the portion of the payment applicable to the additional benefits described in § 417.592. This no-payment rule is effective from the first day of the month following the month of election to receive hospice care, until the first day of the month following the month in which the enrollee resumes normal Medicare coverage.

(b) During the time the election is in effect, the HMO or CMP may bill CMS